STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	01/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

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F0000	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00118544 and Complaint IN00119399 completed on 11-19-2012. Complaint IN00118544 -- Not Corrected. Complaint IN00119399 -- Corrected. Survey dates: January 7 and 8, 2013 Facility number: 000272 Provider number: 155377 AIM number 100274710 Survey team: Penny Marlatt, RN Census bed type: SNF/NF: 77 Total: 77 Census payor type: Medicare: 8 Medicaid: 65 Other: 4 Total: 77 Sample: 3 These deficiencies reflect state	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation ofregulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after January 23, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	findings cited in accordance with 410 IAC 16.2. Quality review 1/14/13 by Suzanne Williams, RN			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure physician orders for medication were followed, resulting in the incorrect dosage of a medication for diabetes given to a resident for 4 days, for 1 of 3 residents reviewed for physician orders for medication administration in a sample of 3. (Resident #F) Findings include: The clinical record of Resident #F was reviewed on 1-7-13 at 2:00 p.m. Her diagnoses included, but were not limited to diabetes, peripheral neuropathy, high blood pressure, osteoarthritis and degenerative disc disease. Her admission Minimum Data Set assessment, dated 12-21-12, indicated she was cognitively intact. On 1-7-13 at 11:03 a.m., the Director of Nursing Service (DNS) provided a copy of a document indicating a medication error had been identified by the facility for Resident #F on	F0282	**F 282 Services Provided Meet Professional Standards** It is the policy of the facility to provide services utilizing qualified persons in accordance with each residents plan of care.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Upon finding medication error on 1/5/13 resident F received head to toe assessment with no new findings; vital signs were taken and were within normal limits. Physician and resident responsible party were re-notified during survey and a new order was obtained from physician. · Resident F receives medications per MD order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · Residents who reside in this facility have the potential to be affected by the alleged deficient practice. · Medication administration record rewrites from December 2012 going into January 2013 will be audited to ensure there are no further	01/23/2013

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	1-5-13. Review of the nursing progress notes, dated 1-5-13 at 2:50 p.m., indicated, "Tradjenta [medication for diabetes] 5 mg [milligram] received BID [twice daily.] Medication corrected immediately. MD notified, DNS and resident aware. Resident is own POA [power of attorney]. No new orders given from MD. Fingersticks [blood sugar results] within normal range. Head to toe assessment performed with no new findings. Vital signs taken upon finding Tradjenta 5 mg given BID. All vital signs WNL [within normal levels]." Review of the physician's admission orders, dated 12-14-12, indicated the resident was to receive Tradjenta 5 mg once daily by mouth. Review of the December 2012 Medication Administration Record (MAR) indicated this medication was documented as ordered by the physician with an administration time of 8:00 a.m. daily and administered from 12-15-12 through 12-31-12 at this time by facility staff. Review of the January 2013 recapitulation orders indicated to administer Tradjenta 5 mg once daily		transcription errors. Any errors found will be addressed and corrected per facility policy. · Licensed Nurses including Nurse Managers will be inserviced on Medication Order Change Policy and by the Director of Nursing Services Consultant on 1/23/13. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nurses Managers will be completing monthly medication administration record rewrites and will be assigned to each others rewrites as a double check. Charge nurses will no longer be completing rewrites. This system will be reviewed with DNS and nurse managers by Director of Nursing Consultant on 1/23/13. · The director of nursing is responsible for compliance related to medication order changes and medication error procedures. · Non-compliance with medication order changes and medication error procedures may result in further education, and/or disciplinary action up to termination. · Licensed Nurses including Nurse Managers will be inserviced on Medication Order Change Policy and by the Director of Nursing Services Consultant on 1/23/13. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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	by mouth. In the section which identifies the time in which the medication is to be administered, the typed administration time of "4pm" was marked out with a line and the time of "8am" was written in above the typed time. Review of the January 2013 MAR on 1-8-13 at 8:50 a.m. indicated Tradjenta 5 mg was administered twice daily on 1-1-13, 1-2-13, 1-3-13 and 1-4-13. The January 2013 MAR indicated a written administration time of 8:00 a.m. and a second time that was unreadable as the second time frame was marked out. On 1-8-13 at 11:40 a.m., an observation of a count of the current supply of Resident F's Tradjenta 5 mg was conducted with the Corporate Nurse and the DNS. A 30-day supply of this medication was dated 12-18-12 with 5 tablets remaining. This would indicate 4 additional tablets were administered to the resident, which would be consistent with 4 days of use twice daily, as opposed to the ordered once daily. In interview with the DNS on 1-8-13 at 11:44 a.m., she indicated the medication error was related to the MAR paperwork is a multi-part document. She indicated the nurse		**program will be put into place?** · Nurse Managers will audit new orders for accuracy and completeness daily times four weeks then Monday through Friday thereafter. · A Medication Errors CQI tool will be utilized by the director of nursing and/or designee twice weekly x 4 weeks, monthly x 2 months and quarterly X 1 for at least 6 months. · A Medical Records CQI tool will be utilized by the director of nursing and/or designee twice weekly x 4 weeks, monthly x 2 months and quarterly X 1 for at least 6 months. Audit tools will be submitted to the CQI committee and if threshold of 95% is not achieved ,action plans will be developed as needed.	

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	who reviewed the January 2013 recapitulation orders did mark out the 4:00 p.m. dose and replaced it with the 8:00 a.m. administration time. She indicated that due to the multi-part document, this information did not properly transfer to the actual MAR for Resident #F as this is the last portion of the multi-part document. The DNS provided a copy of a policy entitled, "Medication Order Changes," with a revision date of 7-2011. This policy indicated, "Purpose: To establish a uniform procedure to be followed to ensure physician's medication order changes are carried through. To ensure residents receive medications as ordered by the physician...When the directions of a medication currently in use have been changed, the nurse will...If only part of the order is changing, the entire previous order must be discontinued and the entire new order must be written...Immediately enter the new medication order on the resident's MAR/TAR [Treatment Administration Record] form. Draw a line through the medication being change [sic] and document 'd/c'd order changed,' the date, time, and his/her signature/initials. Do not alter existing order."			

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	This federal tag was cited on 11-19-12. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint IN00118544. 3.1-35(g)(2)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review, the facility failed to ensure correct medication administration time documentation of a diabetic medication was completed in order to eliminate a medication administration error of the same medication for 4 days, for 1 of 3 residents reviewed for correct medication administration documentation in a sample of 3. (Resident #F) Findings include: The clinical record of Resident #F was reviewed on 1-7-13 at 2:00 p.m. Her diagnoses included, but were not limited to, diabetes, peripheral neuropathy, high blood pressure, osteoarthritis and degenerative disc	F0514	**F 514 Resident Records-Complete/Accurate/Accessible** It is the policy of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Upon finding medication error on 1/5/13 resident F received head to toe assessment with no new findings; vital signs were taken and were within normal limits. Physician and resident responsible party were re-notified during survey and a new order was obtained from physician. · Resident F receives medications per MD order. **How will you identify other residents**	01/23/2013

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	disease. Her admission Minimum Data Set assessment, dated 12-21-12, indicated she was cognitively intact. On 1-7-13 at 11:03 a.m., the Director of Nursing Service (DNS) provided a copy of a document indicating a medication error had been identified by the facility for Resident #F on 1-5-13. Review of the nursing progress notes, dated 1-5-13 at 2:50 p.m., indicated, "Tradjenta 5 mg [milligram] received BID [twice daily.] Medication corrected immediately. MD notified, DNS and resident aware. Resident is own POA [power of attorney]. No new orders given from MD. Fingersticks [blood sugar results] within normal range. Head to toe assessment performed with no new findings. Vital signs taken upon finding Tradjenta 5 mg given BID. All vital signs WNL [within normal levels]." Review of the physician's admission orders, dated 12-14-12, indicated the resident was to receive Tradjenta 5 mg once daily by mouth. Review of the December 2012 Medication Administration Record		**having the potential to be affected by the same deficient practice and what corrective action will be taken.** · Residents who reside in this facility have the potential to be affected by the alleged deficient practice. · Medication administration record rewrites from December 2012 going into January 2013 will be audited to ensure there are no further transcription errors. Any errors found will be addressed and corrected per facility policy. · Licensed Nurses including Nurse Managers will be inserviced on Medication Order Change Policy and by the Director of Nursing Services Consultant on 1/23/13. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nurses Managers will be completing monthly medication administration record rewrites and will be assigned to each others rewrites as a double check. Charge nurses will no longer be completing rewrites. This system will be reviewed with DNS and nurse managers by Director of Nursing Consultant on 1/23/13. · The director of nursing is responsible for compliance related to medication order changes and medication error procedures. · Non-compliance with medication order changes and medication error procedures	

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	(MAR) indicated this medication was documented as ordered by the physician with an administration time of 8:00 a.m. daily and administered from 12-15-12 through 12-31-12 at this time by facility staff. Review of the January 2013 recapitulation orders indicated to administer Tradjenta 5 mg once daily by mouth. In the section which identifies the time in which the medication is to be administered, the typed administration time of "4pm" was marked out with a line and the time of "8am" was written in above the typed time. Review of the January 2013 MAR on 1-8-13 at 8:50 a.m. indicated Tradjenta 5 mg was administered twice daily on 1-1-13, 1-2-13, 1-3-13 and 1-4-13. The January 2013 MAR indicated a written administration time of 8:00 a.m. and a second time that was unreadable as the second time frame was marked out. On 1-8-13 at 11:40 a.m., an observation of a count of the current supply of Resident F's Tradjenta 5 mg was conducted with the Corporate Nurse and the DNS. A 30-day supply of this medication was dated 12-18-12 with 5 tablets remaining. This would indicate 4 additional		may result in further education, and/or disciplinary action up to termination. · Licensed Nurses including Nurse Managers will be inserviced on Medication Order Change Policy and by the Director of Nursing Services Consultant on 1/23/13. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Nurse Managers will audit new orders for accuracy and completeness daily times four weeks then Monday through Friday thereafter. · A Medication Errors CQI tool will be utilized by the director of nursing and/or designee twice weekly x 4 weeks, monthly x 2 months and quarterly X 1 for at least 6 months. · A Medical Records CQI tool will be utilized by the director of nursing and/or designee twice weekly x 4 weeks, monthly x 2 months and quarterly X 1 for at least 6 months. · Audit tools will be submitted to the CQI committee and if threshold of 95% is not achieved, action plans will be developed as needed.	

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	tablets were administered to the resident, which would be consistent with 4 days of use twice daily, as opposed to the ordered once daily. In interview with the DNS on 1-8-13 at 11:44 a.m., she indicated the medication error was related to the MAR paperwork is a multi-part document. She indicated the nurse who reviewed the January 2013 recapitulation orders did mark out the 4:00 p.m. dose and replaced it with the 8:00 a.m. administration time. She indicated that due to the multi-part document, this information did not properly transfer to the actual MAR for Resident #F as this is the last portion of the multi-part document. The DNS provided a copy of a policy entitled, "Medication Order Changes," with a revision date of 7-2011. This policy indicated, "Purpose: To establish a uniform procedure to be followed to ensure physician's medication order changes are carried through. To ensure residents receive medications as ordered by the physician...When the directions of a medication currently in use have been changed, the nurse will...If only part of the order is changing, the entire previous order must be discontinued			

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	and the entire new order must be written...Immediately enter the new medication order on the resident's MAR/TAR [Treatment Administration Record] form. Draw a line through the medication being change [sic] and document 'd/c'd order changed,' the date, time, and his/her signature/initials. Do not alter existing order." This federal tag was cited on 11-19-12. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint IN00118544. 3.1-50(a)(1) 3.1-50(a)(2)			
F9999		F9999	This dose not require a plan of correction.	01/23/2013